Subjunctive medicine: a manifesto

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Abstract

Despite the manifest advantages of modern medicine, many aspects of the experience of illness and healing are not reducible to bodily dysfunction and its restoration. Clinicians and researchers now largely understand that medical practice needs to accommodate a dual aspectivity of the physical body and the lived body. This is increasingly operationalised through the framework of person-centred care, focussed on initiating, integrating, and safeguarding the partnership between the patient-as-person and the clinician-as-person, informed by a narrative perspective on selfhood. In this manifesto, we develop the narrative focus of person-centred care into an alternative framework for medical practice – subjunctive medicine – grounded in ritual efficacy and an explicit appeal to the imagination. We argue that the healing effects of a clinical encounter are reliant on the subjunctive co-construction of a temporary shared social world for a particular purpose. More explicit awareness of the subjunctive nature of the clinical encounter may expand clinicians' opportunities for healing, whilst fostering resilience. We further suggest that, to be fully actualised, subjunctive medicine requires a shift towards conscious appreciation of the nature of subjunctivity at the social level; a social reawakening to the power of the imagination in modern medicine.

Key words

Medical practice; subjunctivity; ritual; person-centred care.

1. Introduction

The advantages of modern medicine are manifest. Life changing discoveries and developments sustain Samuel Johnson's assessment of the medical profession as the greatest benefit to mankind (Porter, 1999). Many medical traditions have proved beneficial, but it is legitimate to ascribe much measurable advancement in healing to the modern, biomedical conception of illness. We are living longer. We are less afraid of disease. Despite such advancement, however, modern medicine has a problem. Many aspects of the experience of illness and healing are not reducible to bodily dysfunction and its restoration: medically unexplained symptoms abound; chronic comorbidities with social determinants are common; recovery can often be achieved without physiological intervention. Overcoming this problem requires understanding the complex interaction of myriad clinical and social factors relevant to each case; a task for which the single-disease, guidelines-based approach of modern medicine is ill-suited (Salisbury, 2012).

This problem has, of course, long been recognised. There are numerous attempts to accommodate what can usefully be described as a dual aspectivity of the physical body and the *lived* body (Fuchs, 2018). Arguably, the dominant approach in modern medicine is *person-centred care* (Ekman et al., 2015; Ekman et al., 2011). In the UK, for example, it is now embedded in guidance from both the Royal College of General Practitioners (2018) and the Royal College of Physicians (2018). Person-centred care has both a long history and a recent resurgence. Grounded in the idea of treating patients as persons, not merely diseases to be treated, it can be traced to the earlier framework termed *patient-centred care* or *patient-centred medicine*. However, despite patient- and person-centred care often being conflated, there are significant differences. In this article we first chart the development from patient- to person-centred care. We then propose that the specific narrative focus of person-centred care can be usefully developed into an alternative framework for accommodating the dual

aspectivity of the physical body and the lived body in medicine; a framework grounded in ritual efficacy and an explicit appeal to the imagination (Kirmayer, 2006).

2. From patient- to person-centred care

Within modern medicine, Edith Balint promoted the dual aspectivity of the physical body and the lived body by contrasting *illness-oriented* medicine focused on localised bodily functions, with *patient-centred* medicine focussed on treating the patient as "a unique human being" (Balint, 1969, 269). In exploring the possibilities of such an approach in practice, Balint (1969, 276) found that doctors "feel that they are not endangered if they allow their patients to tell them what they want in their own time and in their own way". Following a range of proposed definitions over a number of decades, five dimensions of patient-centred care were subsequently proposed: a biopsychosocial perspective; the patient-as-person; sharing power and responsibility; the therapeutic alliance; and the doctor-as-person (Mead & Bower, 2000). Patient-centredness is increasingly influential in both research and clinical settings (Scholl et al., 2014) and is linked to high quality patient care (Langberg et al., 2019).

However, despite attempts to gain consensus, the concept of patient-centredness has been criticised for lacking a unified definition (Ishikawa et al., 2013). This is influenced in part by the lack of specificity in its underlying biopsychosocial perspective. In critiquing the narrow scope of the biomedical model, the biopsychosocial model was presented as a framework in which the social, psychological, and behavioural dimensions of illness could be accommodated (Engel, 1977). This provided an alternative paradigm for research, teaching, and clinical practice. Despite such promise, the model has been criticised for dichotomizing bio-psycho-social elements, masking a bio-bio-bio approach, neglecting cultural factors, and falling short of explaining linkages and hierarchies within it (Benning, 2015; Ghaemi, 2010; Hatala, 2012; McLaren, 1998; Suls & Rothman, 2004).

Moreover, although there is much to admire in patient-centred care, in emerging from the Western tradition it is inevitably informed by the way in which that tradition has altered our conception of the body and what it means to be human. Unlike in other traditions, a Western approach to accommodating the lived body is focussed on the self, the individual and related identity claims (Porter, 1999). This is predicated upon what Seligman et al. (2008) call a 'sincere' orientation to the world; one that presupposes the existence of an authentic self which can be revealed. Accordingly, sincerity (conceived in these terms) has informed a dominant discourse of self-fulfilment that has become progressively detached from interpersonal moral demands and unconditional relationships (Taylor, 1991). In this regard patient-centred care is, anthropologically speaking, unique. The ethnographic record reveals great cross-cultural diversity, but one searches vainly for a medical tradition in which interpersonal engagement between healer and sick person resembles that of patient-centred care.

Although many healing traditions address the patient-as-person, this does not correspond to an individual, 'buffered' conception of it (Taylor, 1989). The patient-as-person in many such societies is often a composite of different elements, which are in unstable relationship with elements that populate the environment. In animistic societies, for instance, one often speaks of the person as the union between 'body' and 'soul' (or 'souls'). Illness is thought to arise when the soul outsteps its bodily boundaries and wanders; or when, by wandering, is snatched by spiritual beings. Medical efforts in such instances are directed at discovering which particular agent has stolen the soul – divination far outweighs treatment in importance – before the shamanic treatment addresses the agent in an attempt to call the soul back (Nathan & Stengers, 2018). By focusing on external entities, healing rituals need not be directed at the sick individual. Even when the treatment does engage the sick individual – usually through dramatic and emotionally moving performance – this engagement is not

aimed at sincerely knowing the person behind the disease. The ritual instead employs a set of culturally accepted constructs (soul, spirits, etc.) and reworks them, enacting a metaphorical transformation that exerts an effect on the sick person's consciousness (Kirmayer, 1993).

Although cross-cultural uniqueness does not, in and of itself, constitute a direct challenge to patient-centred care, it at least questions its wisdom. A more direct challenge can be found in ethnographic research showing that, even in modern medicine, sincere engagement with the patient as "a unique human being" (Balint, 1969, 269) – a discrete self – is often not the way consultations are conducted. Working among occupational therapists in a North American hospital, Cheryl Mattingly (1998) showed how patients and clinicians co-create narrative worlds that are not merely mimetic, but active processes of sense making: patients and clinicians emplot particular actions to develop usefully towards recovery. In exploring the diagnosis and treatment of atherosclerosis in a Dutch university hospital, Annemarie Mol (2002) showed how medicine enacts its objects of concern and treatment. If we accept this premise, rather than understanding the unique person behind the disease, as patient-centred care would prescribe, we must instead understand how each enactment of treatment is appropriate to the situation in hand.

Informed by the narrative account foregrounded by Mattingly and others, a recent approach has seen a move from patient- to *person*-centred care. This move – promoted by the University of Gothenburg Centre for Person-Centred Care (GPCC) – is founded on the premise that a focus on the 'patient' objectifies and reduces that person to a mere recipient of medical services (Ekman et al., 2011). Person-centred care is focussed on initiating, integrating, and safeguarding the partnership between the patient-as-person and the clinician-as-person through three clinical tasks or routines (Britten et al., 2017; Ekman et al., 2015; Ekman et al., 2011): elicit the patient's narrative; share information, deliberation and decision making; and record the patient's narrative and shared goals.

Proponents of person-centred care are keen to distance the framework from patient-centred care. However, in isolation, the three underlying routines can be interpreted as analogous with routines derived from its ancestor. Eliciting the patient's narrative seems close to Balint's (1969, 276) call for doctors to "allow their patients to tell them what they want in their own time and in their own way"; as others have noted, "the theme of sharing medical power and involving patients is an almost universal element of published descriptions [of patient-centred care]" (Mead & Bower, 2000, 1090); and a more recent focus on the co-ordination of care (Langberg et al., 2019) reflects the focus in person-centred care on safeguarding the clinician-patient partnership through documentation. The most significant difference between patient- and person-centred care derives from the latter's underlying philosophy of personalism (Britten et al., 2017; Ekman et al., 2015).

Personalism is a wide-ranging philosophical term with many attributions. The Gothenburg model of person-centred care's version is grounded in Paul Ricoeur's hermeneutics of selfhood, as presented in his 1986 Gifford Lectures (Ricoeur, 1992). Person-centred care derives its narrative focus from this account. For Ricoeur, narrative plays a central role in both the creation and maintenance of identity in a framework whereby one's self is conceived in terms of action and potentiality, through attestation by oneself and others. It does so by mediating between two aspects of identity. On the one hand, *idem* or sameness; a person as a substance in time and space. On the other, *ipse* or the being of self; a person as a changing reflexive being with history. Narratives are thus indispensable for person-centred care as they synthesise *idem* and *ipse* into what Ricoeur – taking from Hannah Arendt – calls a narrative identity. The 'person' in person-centred care, therefore, must be interpreted within an emerging web of relations rather than the 'buffered' individual of patient-centred care. This allows person-centred care to be more usefully integrated with alternative frameworks such as, for example, family-centred or relationship-centred care.

However, despite the dispersed narrative notion of the Ricoeurian self that underpins the Gothenburg model of person-centred care, as others have noted it is difficult to castoff "the assumption that the patient narrative corresponds to the authentic and individual testimony of a unique… person" (Naldemirci et al., 2018, 61). This is exacerbated by statements in key person-centred care papers that suggest a more individualised, unique self, insofar as person-centred care is focussed on "the importance of knowing the person behind the patient" (Ekman et al., 2011, 249). In such terms, the 'sincere' orientation appears retained. Moreover, although we agree with recent critical developments in person-centred care that focus "on the interaction – that which connects different actors – rather than on the individual person" (Naldemirci et al., 2018, 67), we suggest that such a positioning may be difficult to achieve. By the time one has stretched the grammar of the term 'person-centred' past a focus on the individual to interactions in a web of contextual relations, it is unsurprising that confusion exists. To avoid such confusion, some researchers suggest "incorporating… the key features of person-centredness – but at the same time refraining from using the term" (Leplege et al., 2007, 1565).

The practical validity of stretching the grammar of the term 'person-centred' notwithstanding, the narrative focus of the Gothenburg model of person-centred care informs our proposed framework to accommodate the dual aspectivity of the lived body and the physical body in modern medicine. In an ethnography of a general practice surgery in England, researchers led by one of us developed Mol's proposal that medicine enacts the objects of its concern and treatment (Hardman et al., 2020). Developing a dispositional account of general medical practice, Hardman et al. proposed that clinicians develop and adapt the good habits necessary for general practice by adopting a second-order, meta-habit of enaction, insofar as they conceive of each consultation as collaboratively enacted. Hardman et al. tentatively suggested that such an explicitly imaginative and participatory

account reveals an important feature of the general practice consultation: it is conducted as much in the subjunctive as the indicative mood. From this proposition, they proposed a framework for medical practice termed *subjunctive medicine*. Given that Rita Charon alluded to the importance of subjunctivity when acting with narrative knowledge in healthcare – "with such knowledge, we enter others' narrative worlds and accept them – at least provisionally – as true" (Charon, 2006, 10) – we suggest that this tentatively proposed framework for medical practice offers a useful revision of the dominant approach of person-centred care. Drawing on philosophy, linguistics, anthropology, and cognitive science, here we explicate subjunctivity and its consequences for medicine in more detail.

3. Subjunctivity

The concept of subjunctivity is grounded in linguistics. Although our interpretation is broadly socio-cultural, the two dimensions are related. As such, we first explore a linguistic interpretation of subjunctivity – with respect to conditional sentences – from which we develop our more socio-culturally influenced account, grounded in ritual efficacy and the importance of the imagination.

3.1. The linguistic dimension of subjunctivity

Linguistically, the subjunctive is a grammatical mood used to express possibilities or hypotheticals (an *irrealis* mood), which can be compared with the indicative used to express statements of fact (a *realis* mood). A conditional sentence provides a scenario described by an antecedent and then makes a claim about it in its consequent. The grammatical division between the subjunctive and indicative is reflected in the two broadly available kinds of conditional sentences (Iatridou, 2000; Lewis, 1973; von Fintel, 2012). In the indicative mood, the consequent of a conditional (e.g. good interpersonal understanding between patient and clinician) can only seriously be considered if the antecedent (a genuinely engaged clinician) holds outside the particular situation (the consultation). In other words, in the indicative

mood we take the antecedent to hold across all possible social worlds. However, in the subjunctive mood the consequent of a conditional can be seriously considered even if the antecedent does not hold so completely (*if* he had done X, Y *would* have happened). This can be understood linguistically as when a layer of past tense morphology is used modally rather than temporally as an exclusion feature, which distinguishes the discussed social worlds from the speaker's actual one (Iatridou, 2000; von Fintel, 2012).

The debates on counterfactuals and subjunctive conditionals in linguistics and philosophy are manifest and well beyond the scope of this article. For our purposes, it is enough to say, first, that a conditional – whether indicative or subjunctive – provides a scenario in which the antecedent holds. And second, that in a subjunctive conditional the scope of such holding is particular. This notion of *subjunctive conditionality* highlights that, through our use of language, we can usefully create temporary shared social worlds for a particular purpose. The psychologist Paul Harris (2000) argued that such capacity to imagine alternative worlds and their implications is vital to child development. The biological anthropologist Terrence Deacon (1997, 22) went so far as suggesting that such a "shared virtual world" marks humans out as a symbolic species. Jerome Bruner – so integral in connecting the disciplines of psychology and anthropology – was even more explicit. In proposing two complementary yet irreducible modes of cognitive functioning, logico-scientific and narrative, Bruner (1986, 26) argued that the latter relies on the ability to express human possibility and contingency through "*subjunctivising reality*". The importance of contingency, possibility, and the creation of shared social worlds leads to our socio-cultural interpretation of subjunctivity that more directly supports our thesis.

3.2. The socio-cultural dimension of subjunctivity

In socio-cultural terms, the subjunctive mode of experience finds its maximal expression in ritual (Seligman et al., 2008). Rituals enact an imaginary 'as if' social world

delimited in time and space. They do not comprise behaviours that express propositional views about the nature of the world which participants ordinarily hold. They comprise actions that, instead, mark a decoupling, in both act and intention, from the indicative mode of everyday engagement. During ritual processes, common ontological and epistemological debates can be deflated. Confucius expressed this well: famously uninterested in whether spirits exist or not, he nevertheless insisted that when "he offered sacrifice to his ancestors he felt as if his ancestral spirits were actually present" (Chan, 1963, 25). As in a game, where rules depart from those of ordinary life, participants consciously engage in a distinct domain of action, and yet find no fundamental contradiction in doing so. One of the main differences between the two is that rituals, unlike most games, can have deep transformative power.

To people who live in contexts where so-called 'world-religions' are dominant, rituals often appear as formalised rule following. Although this characterisation is ascribable to some ceremonies of the doctrinal, liturgy-based 'world-religions', it does not apply to many observed ritual performances, especially healing performances (Csordas, 1987). The anthropologist Arnold Van Gennep (1908/1960, 13) theorized the transformative effects of such acts, proposing that rituals almost invariably "accompany transitions from one situation to another and from one… social world to another". Focusing mostly on rites of passage such as initiations, marriages or funerals, he noted that the central part of ritual – its *liminal phase* – has very few attributes of the previous and subsequent phases. In the liminal phase, after severing ties with their previous situation, the participant goes through a state of ambiguity involving complex and unconventional symbolism, emerging as a new person in some important respects. As Victor Turner (1980) later added, this phase takes place in a subjunctive mood. In classic rites of passage, this transforms social identity. In healing rituals, it potentially transforms health. This contrasts with the claim in person centred care

that “ritualistic… care processes… afford few opportunities for the formation of meaningful patient–provider relationships” (Ekman et al., 2011, 249).

As we infer from linguistics, the subjunctive is primarily a realm of possibility (perhaps more accurately, *virtuality* (Deleuze, 1968/2014)): a realm in which novel configurations of ideas and relations, unentertained in ordinary indicative life, are explored and enacted. As Turner (1980, 164) put it, in ritual “actuality takes the sacrificial plunge into possibility and emerges as a different kind of actuality”. The liminal domain of ritual is one that nurtures emotional states such as desire, wish, hypothesis, uncertainty, and play. Healing rituals, in particular, foster a mood of *hope* (Kube et al., 2019). Many medical traditions enhance this mood through symbolism that presupposes, in its very framing, the possibility of transformation. For example, casting illness in terms of recoverable soul-loss already implies the possibility of healing. What the ritual later enacts is a search for the afflicting agent and the retrieval of the soul. The ritualised setting and processes enable the patient to attach their emotions to particular symbols, which the healer gradually manipulates, resulting in emotional transformation (Dow, 1986; Kirmayer, 1993).

The particular aesthetics of ritual performance are fundamental to the transformative goal of healing rituals. Music, touch, drama, and visual symbols act as cognitive and emotional *shifters* (Hinton & Kirmayer, 2016) that help the sick person disengage from rigid mind-frames and slide into a subjunctive mood. We suggest that the same process, though under-acknowledged, happens in secular, biomedical settings. The operating room, for instance, is a setting discontinuous with everyday life, typified by high-tech paraphernalia and arbitrary forms of behaviour, and most importantly by an obsession with maintaining boundaries (motivated partly by a real concern over infection) (Katz, 1981). The primary care clinic, as a circumscribed domain in which particular symbols and stylised behaviour appear

to the patient, has many of the same attributes (Berger & Mohr, 2016). These contexts show structural similarities with healing rituals witnessed by anthropologists around the world.

The potential productive capacity of liminality and subjunctivity has been explored more minimally in modern medical contexts, with respect to uncertainty in illness experience (Dauphin et al., 2019; Frumer, 2017; Good & Del Vecchio Good, 1994; Whyte, 2005). In rejecting traditional accounts of uncertainty in medicine – wherein uncertainty arises when patients are unable to make sense of their experience (Mishel, 1981, 1988) – a subjunctive interpretation suggests uncertainty can instead stimulate meaning *making* and coping processes (Dauphin et al., 2019). Further implicit manifestations of subjunctivity in modern medicine can be seen in its attempts to treat mental ill health. In taking a narrative perspective on therapy, White and Epston (1990) proposed that therapists seek to establish counterplots to their clients' entrenched problems, and that this process occurs more in the subjunctive than the indicative mood. This use of the subjunctive is arguably not constrained to narrative therapy (Hedtke & Winslade, 2005). As the psychiatric profession has realised, the categories used to diagnose mental illness – institutionalised in the Diagnostic and Statistical Manual of Mental Disorders – are, in themselves, interpretations. Yet despite the fictive nature of diagnostic categories, the process of labelling can help to acknowledge a patient's suffering and offer a coherent explanation of their symptoms – not unlike the shaman who explains a person's illness through the idiom of soul-loss. The potential therapeutic value of fiction, created between clinician and patient, is also important in psychoanalysis through the concepts of 'transference' or the 'transitional object' (Winnicott, 2005).

Many anthropological accounts suggest that healing rituals, whether conducted in the modern clinic or the shaman's hut, are subjunctive in character. Beyond such accounts, we further propose that what in modern medicine is misleadingly called the 'placebo effect' is in fact the effect of ritualization in a subjunctive mode. In a pioneering study, Stewart Wolf

(1950) demonstrated that the nausea-inducing action of ipecac depended on verbal suggestion and that the effect may be more potent than the characteristic pharmacologic action. Other studies reinforce the idea that beliefs, in some form, might influence patients' response to treatment (Colloca & Miller, 2011; Kirsch, 1985; Lasagna et al., 1954; Levine et al., 1978). Further studies have identified potential neurobiological mechanisms underpinning these findings (Amanzio & Benedetti, 1999; Eippert et al., 2009).

More directly related to ritual and subjunctivity, the placebo effect varies depending on the type and character of treatment. This is plausibly explained by the different aesthetic quality of such treatments. For example, sham surgeries are often more effective than 'placebo pills' for the same condition because of the high-tech paraphernalia and the powerful aesthetic hold they have on the patient (Goetz et al., 2008; Moerman, 2002). The same considerations apply to a healer's persona. The powerful effect that a doctor or healer can have on a patient is partially attributable to their ability – often expressed in non-verbal demeanour (e.g. Ramseyer & Tschacher, 2011; Tschacher et al., 2014) – to help the patient shift into a subjunctive engagement with the healing encounter. Such an interpretation of the placebo effect suggests it represents not the power of a pill but the power of ritual, insofar as "'placebo' names a social situation not a substance" (Kirmayer, 2011, 121).The pragmatist philosopher John Dewey (1938/1998, 384) defined such a social situation as an "environing experienced world", in which organisms and the environment are coupled in dynamical relations (Gallagher, 2017). In such terms, the 'placebo effect' (and thus the effect of subjunctive medicine) is the effect of a social world subjunctively co-constructed (enacted) by clinician and patient. Such a pragmatist interpretation develops the deflationary epistemological orientation of subjunctive ritual processes. Dichotomies such as knowing and believing, truth and falsehood, are replaced with a notion of making indeterminate situations determinant through a focus on conceived practical effects (Peirce, 1878/1982). And as

Charles Sanders Peirce would propose in his later formulation of the 'pragmatic maxim', such focus on conceived practical effects requires a subjunctive formulation (Misak, 2004, 2013).

Recent findings have further shown that the placebo effect can occur even if the patient knows that the treatment is a placebo, through what is termed 'open-label' placebo treatment (Carvalho et al., 2016; Kaptchuk et al., 2010; Sandler et al., 2010; Zhou et al., 2019). This result has been widely perceived as counterintuitive, but if we understand treatment as taking place in a subjunctive mode, the problem dissipates. It is precisely because ritual entails a decoupling from everyday life that the indicative knowledge about the 'placebo' as an inert substance is, to a degree, inconsequential. During the process of ritualization, the patient is induced to act 'as if' the 'placebo' had the potential to be an effective medicine. There are valid critiques of open-label placebo treatment, most notably its potential practical validity (Ainsworth et al., 2019; Miller, 2018). Nevertheless, in line with our broader assessment of the placebo concept, even if direct open-label placebo treatment does not prove useful, open-label placebo experiments still provide proof of concept for the subjunctive character of healing rituals in modern healthcare environments (Kaptchuk, 2002, 2011; Kaptchuk et al., 2009; Myers, 2010); as one of us has previously suggested, the effects of open-label placebo treatment are not caused by the 'inert' pill itself, but by the construction and exploitation of a whole treatment situation (Ainsworth et al., 2019).

4. Subjunctive medicine

Findings from linguistics, anthropological interpretations of ritual, and placebo studies research support the proposition that effective healing encounters are subjunctive in character. Existing research on subjunctivity in modern medicine has focussed minimally on the implications of uncertainty in illness experience, inasmuch as such uncertainty can, in a subjunctive mode, be productive. In a recent ethnography, one of us argued that the

subjunctive character of medical practice is more extensive, proposing three principal actions that comprise such a form of medical practice (Hardman et al., 2020, 7): "conceive of each consultation as collaboratively enacted anew; exploit the importance of the imagination in developing interpersonal relationships; explicitly adopt a clinical role to improve resilience". To conclude our account, we expand these actions into a more complete manifesto for subjunctive medicine, which reflects both the interpersonal and social consequences of practising subjunctive medicine.

In interpersonal terms, subjunctive medicine is not just a case of clinicians applying the principles of good evidence-based clinical practice to their presenting patient. It is instead an action-oriented, generative process of co-construction particular to each encounter. Through such co-construction, the consultation carries its own mode of directed intentionality that minimises the internal states of the clinician and patient. This, in part, accords with recent critical interpretations of person-centred care which focus "on the interaction… that… connects different actors" (Naldemirci et al., 2018, 67). Despite such focus, however, we do not advocate a thin behaviourist notion of action set against 'sincere' intent. As others have noted more generally, such an approach is as misguided as a modern emphasis on sincerity through which 'authentic' inner motives are privileged over action (Seligman et al., 2008). In explicating subjunctive medicine, we instead promote a *re-balancing* of the subjunctive and indicative in medicine, acknowledging the uniqueness of each enacted and embodied consultation, and the tension between its connection with and separation from everyday life.

We propose that clinicians should exploit the ritual-like structure of the consultation and the opportunities for resilient interpersonal connection the subjunctive mode affords. This may include acting in different ways, for different patients, with different conditions, at different times. This may include clinicians presenting a persona related to but removed from the way in which they act in everyday life. As other researchers have alluded to, one way to

improve clinicians' capacity to practise subjunctively may be to incorporate contemporary performance practices into modern medical education, including: opportunities for active rehearsal in simulation settings rather than through scripted role-play; increased emphasis on improvisation in training; and increased exposure to medically oriented literature and theatre (Hooker & Dalton, 2020).

As one of us noted in the ethnography in which the framework was created, subjunctive medicine does not provide a distinct set of routines or tasks for clinicians to accomplish (Hardman et al., 2020); given the existing complexity of modern medical practice, one could argue clinicians need fewer routines, not more. Instead, it promotes a change in mindset, whereby clinicians, in the words of a GP in the initial ethnography, can become more "imaginative with how… [they] approach people" (Hardman et al., 2020, 7). Thus, by promoting the importance of the imagination in modern medicine, we do not suggest clinicians refrain from directly questioning patients; this, of course, is vital. Rather, we propose that the ways in which they enact interpersonal relationships in the clinic should be guided by a Deweyan focus on making the local indeterminate situation determinate. This highlights one useful corollary of subjunctive medicine: it answers the problem of deciding what is relevant to the particular consultation. Because a situation "is dominated and characterized throughout by a… pervasive and internally integrating quality" (Dewey, 1931, 97), subjunctive medicine emphasises that what is relevant to a clinician is not just evidence-based medical guidelines (and the tools and practices by which to implement them) or *a priori* ethical principles or values, but also the person in front of them, their (potentially shared) history, and myriad other factors. What subjunctive medicine also emphasises is that from these myriad factors, what is relevant can only be grasped intuitively in terms of the environing experienced world of which the clinician is an integral part.

This account of subjunctive medicine has largely focussed on the clinician. However, in the co-construction of the clinical encounter within a subjunctive mode, the patient necessarily plays their part too. But as with the dominant framework of person-centred care, this part is largely played without explicit reference to any framework of medical practice. Person-centred care outlines routines to be conducted by the clinician in order to facilitate what many patients already want and attempt to do: i.e. be explicitly involved and foregrounded in decisions on their care, through the development of a partnership with their clinician. Analogous to such an approach, through subjunctive medicine we attempt to enable clinicians to facilitate what many patients already want and attempt to do. As evidenced in the initial ethnography (Hardman et al., 2020), patients – as well as clinicians – present a persona in the clinic related to but removed from the way in which they act in everyday life. By practising subjunctively, insofar as they focus on the co-construction of a temporary social world for a particular purpose, clinicians create the conditions for patients to 'enact with' rather than be 'acted on'. Such a temporary world is one "where differences can be accommodated, tolerance enacted (if not fully understood) and openness to others maintained." (Seligman, 2010, 15). The outcome of subjunctive medicine for patients, therefore, is the creation of the conditions most conducive to developing interpersonal understanding and connection with their clinician. Moreover, due to a focus on the *temporariness* of the co-constructed social situation, such connection is not purely reliant on a shared history. This may be increasingly useful as modern medicine, particularly primary care, moves to a more multidisciplinary future in which different aspects of treatment are distributed amongst various healthcare professionals (Royal College of General Practitioners, 2019).

Subjunctive medicine is, in scope, a general framework for accommodating the lived as well as the physical body in modern medicine. As such, it is not *a priori* restricted to

particular conditions or particular specialties. Subjunctive medicine could be practised by all clinicians in all situations. Nevertheless, in focussing on accommodating the *lived* body, the advantages of subjunctive medicine are likely to be greatest where such accommodation is most useful. With respect to particular medical issues this will likely include chronic illness management, multimorbidity, polypharmacy, medically unexplained symptoms, mental health, and conditions whereby social and cultural determinants play a substantial role. With respect to particular medical specialties, subjunctive medicine is likely to be most useful in, for example, primary care, geriatrics, psychiatry, and clinical psychology; and less useful in, for example, emergency medicine and surgery.

As outlined above, our proposition that clinicians and patients should more explicitly exploit the ritual-like temporary co-construction of the medical consultation has potential positive consequences in itself. Nevertheless, we further propose that to be fully actualised subjunctive medicine requires a wider restructuring of the social imagination: a shift towards conscious appreciation of the nature of subjunctivity at the social level. The subjunctive mode has been suppressed by a cultural and institutional emphasis on a 'sincere' orientation towards the world, which only admits the indicative '*as is*' vision of reality (Seligman, 2010; Seligman et al., 2008). This has led to the perception that *'as if'* and '*as is*' visions – complementary in most human societies – are fundamentally incompatible. A societal recognition of subjunctivity would help dispel the concern in modern medicine that treating both the lived body and the physical body is unachievable. The appreciation that medical consultations take place in a circumscribed domain of action – involving concepts and imagined entities unentertained in the indicative mode of ordinary life – would allow clinicians to expand their communicative bandwidth and explore new avenues of effective patient engagement.

It is hard to envisage specifically what a societal recognition of subjunctivity would mean for medical practice. Plausibly, it would include the incorporation of stories, metaphors, narratives and myths into medical consultations, as occurs in some societies whereby "the elementary aspects of… social life are the essential background to… medicine" (Glick, 1967, 39). As such, we envisage subjunctive medicine as compatible, but developing, narrative approaches to medicine (Charon, 2001, 2006; Charon et al., 2017; Mattingly, 1998): compatible, insofar as we acknowledge the importance of 'narrative competence' for medical practice; developing, insofar as we reject the precept in narrative medicine that "practitioners… must be prepared to offer the self as a therapeutic instrument… willing to suffer in the process" (Charon, 2006, 215), instead foregrounding the generative and resilient capacity of the subjunctive mode. In these terms, subjunctive medicine is partly a process of un-concealing existing, local cultural ideas and practices currently underused in modern medicine – through what Charles Taylor (1991) calls a *work of retrieval*.

Beyond such a work of retrieval, subjunctive medicine might also involve the introduction of new metaphors with similar explanatory roles to the concepts of 'soul' or 'spirits' in certain societies and healing traditions. Whatever form such new ideas take, they must not be perceived as incompatible with biomedicine and its exclusive focus on the physical body. By emerging only within the demarcated context of the healing ritual, these would not undermine biomedical naturalism. Instead, they would enhance it. The result would be a broader medical pluralism, without the drawbacks associated with exclusive ideological allegiances to particular therapeutic practices. As anthropologists have shown, in societies not typified by the cultural and institutional dominance of 'sincerity', medical pluralism is the norm. In the ethnographic record it is hard to find widespread ideological commitment to specific healing systems; or, for that matter, ideological tension between modern and traditional medical systems. When in need, people adopt a pragmatic stance –

often shuffling across disparate healing systems – seeking treatments based on available knowledge and resources. What underpins and enables such medical pluralism, we maintain, is the social appreciation of subjunctivity.

5. Conclusion

As we outlined in our introduction, the advances of modern medicine are manifest. To deny that is to deny experience. But as we also outlined, modern medicine struggles to accommodate treatment of the lived body and the physical body. This has caused unnecessary suffering. Developing the narrative focus of the dominant way in which this problem has been addressed – person-centred care – we propose the alternative framework of subjunctive medicine, whereby clinician and patient co-construct a temporary shared social world for a particular purpose. In so doing, we reach past modernity's exaltation of the indicative to a rich cultural history in which subjunctivity and possible worlds have currency (Turner, 1982). We argue that modern medicine should embrace the subjunctive character of the clinical encounter and thus expand opportunities for healing. To fully facilitate this, what is ultimately needed is a social reawakening to the power of the imagination.

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